PATIENT HISTORY FORM

Patient Name:____ Date:______________

In order to evaluate your condition fully, please be as accurate as possible in answering the following questions.

PRESENT ILLNESS OR INJURY:

For what condition or symptoms are we seeing you? ______________________________

When did your symptoms begin? ______________________________

Please describe your symptoms: ______________________________

Have you been treated for this condition in the past? ______________________________

PAIN SCALE (please rate your current pain intensity level)

PAST MEDICAL HISTORY (please indicate if you have had any of the following conditions)

Heart Conditions	☐	Seizures	☐	Hernia	☐
Pacemaker	☐	Cancer	☐	Surgical Implants	☐
Pulmonary Conditions	☐	Arthritis	☐	Pregnant	☐
Seizures	☐	Diabetes	☐		

Other medical conditions not listed: (explain) ______________________________

Surgery (list previous surgeries and date(s) performed) ______________________________

____

Medications: (list all current medications including dosage/frequency) ______________________________

____

FAMILY HISTORY (please indicate of any immediate, blood relative has/had any of the following)

Heart Disease	☐	Cancer	☐	Arthritis	☐
Stroke	☐	Diabetes	☐	Hypertension	☐